DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/23/2011		
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	2216 No	ADDRESS, CITY, STATE, ZIP CODE ORTH RILEY HIGHWAY YVILLE, IN46176	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIV CROSS-REFERENCE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
R0000	This visit was for Licensure Survey	State Residential	R00	000			
	Survey Dates: F	ebruary 21, 22, 23, 2011					
	Facility Number: Provider Number AIM Number: N	r: 004444					
	Survey Team: Patti Allen, BSW TC Diane Dierks, RN Leia Alley, RN (February 21, 22, 2011)						
	Census Bed Type Residential: 10 Total: 10	»:					
	Census Payor Type: Other: 10 Total: 10						
	Sample: 7						
	These State Residuaccordance with	dential Findings are in 410 IAC 16.2.					
	Quality review co 2011 by Bev Fau	ompleted on March 2, Ikner, RN					
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NC0L11

Facility ID:

004444

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII B. WIN	LDING	ONSTRUCTION	(X3) DATE S COMPL 02/23/2	ETED
NAME OF PROVIDER OR SUPPLIER WALKER HOUSE			•	2216 N	ADDRESS, CITY, STATE, ZIP CODE ORTH RILEY HIGHWAY YVILLE, IN46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
R0090	record review, the to Indiana State I call light system affected all reside. Findings include. On the following following observed 2/23/11 at 9:50 a her room sitting it television. The rollights with pull stights with pull stights with pull stight was on the bed and the second in the bathroom. The total activated by this This surveyor exat 10:40 a.m. and outside of the restaum. Staff did not A document, date Communication Wellness Director included, but was following:	date and time, the	R00	90	R 090 410 IAC 16.2-5-1.3 (g) (1-6) Administration and Management What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No reside were found to be affected. The call light system was replaced and operational on March 7, 2011. How the facility will identify other residents having the potential to be affected be the same deficient practice as what corrective action will be taken? No other residents were found to be affected. What measures will be put into plator what systemic changes were the deficient practice does not recur? The Residence Director Wellness Director, and staff were-educated to our policy and procedure concerning our reporting requirements via the ALC Decision Tree and state regulation 410 IAC 16.2-5-1.3 (1-6). The Residence Director and/or the Wellness Director wensure incidents considered reportable are communicated with appropriate personnel as indicated within the ALC Decision Tree and applicable state agencies within 24 hours of occurrence in accordance with 410 IAC 16.2-5-1.3 (g) (1-6). Administration and Management How will the corrective	ed nts ng y nd e ce ill lat ot or, //ere (g) vill	03/11/2011

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If continuation sheet

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PRINTED: FORM APPROVED OMB NO. 0938-0391

03/29/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 02/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2216 NORTH RILEY HIGHWAY WAI KER HOUSE SHELBYVILLE, IN46176 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE frequently until our new call light stem action(s) will be monitored to ensure the deficient practice arrives. Check every resident at least will not recur, i.e., what quality hourly..." assurance program will be put into place? The Residence During an interview on 2/23/11 at 10:45 Director and/or Wellness Director will perform an ongoing daily a.m., the Wellness Director indicated that review of incidents to ensure none of the call lights in the facility were continued compliance with working and they (the facility) were applicable state reporting getting a new sytem and the staff was guidelines as indicated by state ruling 410 IAC 16.2-5-1.3 (g) (1-6) performing checks on residents. Administration and Management Findings will be reviewed and During an interview on 2/23/11 at 11:01 corrected through our QA a.m., the Acting Administrator indicated process. By what date will the that some of the call lights had stopped systemic changes be completed? Compliance Date: transmitting on 2/4/2011 and he ordered a 3/11/11 new call light system on 2/8/11. During an interview on 2/23/11 at 11:15 a.m., the Wellness Director indicated that staff was to check on residents every 1/2 hour to 1 hour and this was recorded in the Communication book that is read by the staff. When asked how residents were to call for help while the call light system was not working, the Wellness Director stated, "I guess they wouldn't be able to." During an interview on 2/23/11 at 11:36 a.m., the Wellness Director indicated that not all rooms have phones and it is the choice of the residents and the residents must pay for phones. She indicated there was only 1 resident in the facility who did

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION	(X3) DATE COMP 02/23/2	LETED
NAME OF PROVIDER OR SUPPLIER WALKER HOUSE			STREET A 2216 No	ADDRESS, CITY, STATE, ZIP CODE ORTH RILEY HIGHWAY YVILLE, IN46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	indicated that sig 2/23/11 in reside phone number for assistance and sharesidents whom able to use a phocognition. She is residents do not the facility. During an intervent, the Acting he could not find State Department the call light sys. He indicated fand been notified the functioning and families that even new call light sys supplier on Frida arrive at the facil Wednesday. During an intervent, the Acting copy of the pure call light system.	e in the room. She gas were being posted on ent rooms that displayed a or residents to call for ne would provide a list of she believed would not be one due to impaired indicated that most usually use call lights in iew on 2/23/11 at 2:00 Administrator indicated d any record of Indiana it of Health being notified tem was not functioning. inlies of residents had not e call light system was not they (staff) would notify ning. He indicated the stem would ship from the ay, 2/25/2011, and would lity the following iew on 2/23/11 at 2:20 Administrator provided a hase order for the new with an order date of itted on the purchase				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII B. WIN	LDING	ONSTRUCTION	(X3) DATE SUF COMPLETI 02/23/201	ED
NAME OF PROVIDER OR SUPPLIER WALKER HOUSE				2216 N	ADDRESS, CITY, STATE, ZIP CODE ORTH RILEY HIGHWAY YVILLE, IN46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	(X5) OMPLETION DATE
R0185	Based on observer record review, the that residents we help using the farwas discovered of Resident #1's cal residents in the farmation for the record for Residents in the farmation on 2/21/11 at 2:3 Diagnoses for Resident were not limited ideation, hyperted disease, kidney so Alzheimer's disease. On the following following observed 2/23/11 at 9:50 and her room sitting television. The relights with pull so light was on the bed and the second in the bathroom. The call activated by this	ation, interview and e facility failed to ensure re able to summon for cility call system. This during the testing of l system and affected all acility. d: esident # 1 was reviewed 0 p.m. esident # 1 included, but to, depression, suicidal nsion, peripheral vascular tone, dementia and ase.	R01	85	Citation #2 R 185 410 IAC 16.2-5-1.6 (i) (1-2) (A) (i-iii) (B-E) Physical Plant Standards What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice? No residents were found to be affected. The call light system were replaced and operational on Marc 2011. How the facility will identify offected by the same deficient practice and what corrective action will be taken? No other residents were found to affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does recur? The Residence Director, Wellness Director, and staff were re-educated to state ruling 410 IAC 16.2-5-1. (1-2) (A) (i-iii) (B-E) and our poland procedure concerning the AID Decision Tree. The Residence Director and/or Wellness Director will ensure going forward the Regional team is consulted in the event of a physical plant issue or state reportable event for appropriate to state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state reportable event for appropriate in the event of a physical plant issue or state t	e s this as ch 7, her be be be licy C r	3/07/2011

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING		COMPLETED		
			A. BUI			02/23/2011		
	B. WING STREET ADDRESS, CITY, STATE, ZIP COI			ADDRESS SITE STATE SID CODE				
NAME OF F	PROVIDER OR SUPPLIER	1		1				
\\\\\	NUCLIOF			1	ORTH RILEY HIGHWAY			
WALKER	HOUSE			SHELB	YVILLE, IN46176			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	at 10:40 a.m., an	d waited in the hall	I		follow up and intervention.			
	outside of the res	sident's room until 10:45						
		ot respond to the call			How will the corrective action(s	·		
	light.	or respond to the can			will be monitored to ensure the	l l		
	ngnt.				deficient practice will not recur	,		
		12/4/44 2 1 2 22			i.e., what quality assurance			
	·	ed 2/4/11, from the Staff			program will be put into place? The Residence Director and/or			
	Communication	book provided by the			Wellness Director will conduct a	n		
	Wellness Directo	or on 2/23/11 at 2:30 p.m.,			ongoing daily review of incidents	•		
	included, but wa	s not limited to, the			ensure continued compliance wit			
	following:				state ruling 410 IAC 16.2-5-1.6 (
					(1-2) (A) (i-iii) (B-E) Physical Pl	ant		
	"Attention staff r	olease check residents			Standards. Findings will be revie	wed		
		our new call light stem			and corrected through our QA			
		· ·			process.			
		very resident at least						
	hourly"							
					By what date will the systemic			
	Nursing notes for	r Resident # 1, dated			changes be completed? Compliance Date: 3/7/11			
	1/17/2011 throug	gh 2/11/11, did not			Compliance Date: 3///11			
	`	rly resident checks were						
	completed.							
	completed.							
	D. stare in t	2/22/11 10 45						
	_	iew on 2/23/11 at 10:45						
	-	ss Director indicated that						
		ights in the facility were						
	working and they	y (the facility) were						
	getting a new syt	tem and the staff was						
	performing check							
	3:300							
	During an interv	iew on 2/23/11 at 11:01						
	_							
	_	Administrator indicated						
		call lights had stopped						
	transmitting on 2	2/4/2011, and he ordered a						
	new call light sy	ystem on 2/8/11.						

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AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				COMPLETED		
			B. WING			02/23/2	011
NAME OF PROVIDER OR SUPPLIER			l l		, CITY, STATE, ZIP CODE	•	
					RILEY HIGHWAY		
WALKER HOUSE			SH	LBYVILLE	, IN46176		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFI	(EAC CROSS	THE CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
	_	iew on 2/23/11 at 11:15					
	, , , , , , , , , , , , , , , , , , ,	ss Director indicated that					
		ck on residents every 1/2					
		nd this was recorded in					
		ion book that is read by					
		asked how residents were					
	to call for help w	while the call light system					
	was not working	s, the Wellness Director					
	stated, "I guess t	hey wouldn't be able to."					
	During an interv	iew on 2/23/11 at 11:36					
	a.m., the Wellne	ss Director indicated that					
	not all rooms ha	ve phones and it is the					
	choice of the res	idents and the residents					
	must pay for pho	ones. She indicated there					
	was only 1 resid	ent in the facility who did					
	not have a phone	e in the room. She					
	•	gns were being posted on					
	_	ent rooms that displayed a					
		or residents to call for					
	-	ne would provide a list of					
		she believed would not be					
		one due to impaired					
	*	ndicated that most					
	_	usually use call lights in					
	the facility.	usuany use can rights in					
	the facility.						
	During an interv	iew on 2/23/11 at 2:20					
	_	Administrator provided a					
		•					
		hase order for the new					
		with an order date of					
	"2/23/2011" prin 	ited on the purchase					

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING		(X3) DATE (COMPL - 02/23/2	ETED
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COL ORTH RILEY HIGHWAY	DE .	
WALKE	R HOUSE			SYVILLE, IN46176		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	order. He indica	ted the facility does not garding use of call lights				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WIN			02/23/2011
	PROVIDER OR SUPPLIER R HOUSE	TATEMENT OF DEFICIENCIES		2216 N	ADDRESS, CITY, STATE, ZIP CODE ORTH RILEY HIGHWAY YVILLE, IN46176	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
R0302	interview, the fact the counter medical labeled and 'First marked for medical dates dependent to was opened. This residents (Reside medications were date and for 5 of over the counter 1 #9, #3, #2, #4, #5 Findings Included During and obsert Cart on 2/22/11 apresence of QMA eye drops, all 6 be reviewed for a date opened and giver bottles belonged residents: Resident #3 - 3 medications were dates. Over the Counter were observed in The medications resident 's full nate and/or room numerical and/or room numerical services and the services of the counter were observed in the medications resident 's full nate and/or room numerical services and the counter were observed in the medications resident 's full nate and/or room numerical services and the counter were observed in the medications resident 's full nate and/or room numerical services and the counter were observed in the medications resident 's full nate and/or room numerical services and the counter were observed in the counter were ob	d: vation of Medication t 4:00 p.m., and in the A # 2, 6 opened bottles of ottles of eye drops were te in which they were a to a resident. The to the following ent # 9 - 3 bottles and	R03	02	R 302 410 IAC 16.2-5-6 (c) (6) Pharmaceutical Services Who corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected. How the facility will identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take No other residents were found be affected. What measures who be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director and licensed staff were re-educated to state ruling 410 IAC 16.2-5-6 (c) (6) Pharmaceutical Services. The Wellness Director is to ensure going forward OTC medication are appropriately labeled with following: (1) first opened date (2) expiration date (3) resident name (4) room number (5) physician name (6) directions usage per MD order. How with the corrective action(s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. The Wellness Director and/or Designee will ensure continued compliance through weekly	e II Property of the Property

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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AND PLAN	OF CORRECTION	N IDENTIFICATION NUMBER: A. BUILDING			COMPL	ETED		
			1	B. WING			011	
р. w			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIER				ORTH RILEY HIGHWAY			
WALKER	HOUSE			1	YVILLE, IN46176			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE	
	number. Medica	ations included:			review of medications within th	ne		
					medication cart for properly			
	Mature Vitamin-	name and room number,			labeled OTC medications per			
	belonging to Res				policy and procedure and state ruling 410 IAC 16.2-5-6 (c) (6)			
		nly, belonging to			Findings will be reviewed and	•		
		my, ocionging to			corrected through our QA			
	Resident # 3				process. By what date will the	he		
		elonging to Resident # 3			systemic changes be	-		
	Tylenol- room nu	umber, belonging to			completed? Compliance Date):		
	Resident # 3				3/11/11			
	Iron- no name or	room number, only the						
		', belonging to Resident #						
		, belonging to Resident #						
	2							
		e or "store brand" Zyrtec)-						
	name and room r	number, belonging to						
	Resident # 2							
	Stool Softener (2	generic/store brand)-						
	, •	w to give and "PM"						
		ottle, belonging to						
		ttie, belonging to						
	Resident # 9							
	_	ımber only, shared						
	between Residen	ts # 4 & 5 who are a						
	married couple.							
	•							
	Pavian of a facil	lity policy dated 2005,						
		ckaging and Labeling"						
	indicates that over							
	medications mus	t be identified with the						
	following: Resid	lent's Full Name,						
	_	e, Expiration date, Name						
	J							
					ļ			

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			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				ORTH RILEY HIGHWAY		
WALKER				SHELB	YVILLE, IN46176		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	of drug, Strength						
	or unug, su ungu	01 4149					
	_	iew with Qualified					
		(QMA) #2 on 2/22/11 at adicated that they can					
	identify who the						
		by the name or room					
	number written o	-					